

Health Quality Planning Commission Annual Report

Creating a Healthy Idaho

June 2018

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Acknowledgments

The Health Quality Planning Commission (HQPC) wishes to thank Idaho's major healthcare stakeholders for their selfless contributions to this effort, which include their time and staff resources. Much of the work of the Commission would not be possible without the generous staff support provided by the Department of Health and Welfare, Saint Alphonsus Health System, Regence BlueShield, Blue Cross of Idaho, St. Luke's Health System, Kootenai Health, the Idaho Health Data Exchange, Boise State University, Primary Health Medical Group, and Family Medicine Residency of Idaho.

Foreword

This document is submitted to the Department of Health and Welfare's Director, Russell S. Barron; the Idaho Senate Health and Welfare Committee; and the Idaho House Health and Welfare Committee to meet the requirements set out in House Bill 375 passed by the 2016 Legislature.

Health Quality Planning Commission Members

Chair

Tim Dunnagan, EdD

Dean and Professor, College of Health Sciences,
Boise State University

Vice Chair

(vacant)

Commission Members

Brad Erickson

Executive Director, Idaho Health Data Exchange

Julie Lineberger (fmr)

David Pate, MD

President and CEO, St. Luke's Health System, Boise,
Idaho

Dan Meltzer, MD

SVP and Chief Medical Officer, Blue Cross of Idaho

Rhonda J. Robinson Beale, MD (fmr)

Margaret A. Henbest, RN, MSN,
CPNP

Community Representative, Boise, Idaho

Ted Epperly, MD

Program Director and Chief Executive Officer,
Family Medicine Residency of Idaho, Boise, Idaho

Kenneth Bramwell, MD
Scott Kreiling (fmr)

Medical Director, Regence BlueShield of Idaho, Boise,
Idaho

John Rusche, MD

Pediatrician, Lewiston, Idaho

Casey Meza

Executive Director, Affiliated Health Services, Kootenai
Health

Angela Beauchaine, MD

Pediatrician, Primary Health Medical Group

James Lederer, MD

Chief Medical Officer, Saint Alphonsus Health System

Commission Staff

Robin Butrick &
Lindsay Carlson

Administrative Support and Project Coordination,
Department of Health and Welfare, Boise, Idaho

Tammy Ray (fmr)

Project Manager, Department of Health and Welfare,
Boise, Idaho

** (fmr) – Former member that has resigned

Background

The Health Quality Planning Commission (HQPC) was established by House Bill 738 during the 2006 legislative session, extended with House Bill (HB) 238 in the 2007 legislative session, 2008 with HB 489 and 2016 with house HB 375. The purpose of the Commission is to “...promote improved quality of care and improved health outcomes through investment in health information technology and in-patient safety and quality initiatives in the state of Idaho.”

The Commission is a committee of 11 individuals selected by the Governor’s office and currently led by Dr. Tim Dunnagan, Dean and Professor, College of Health Sciences, Boise State University and the former Director of Health and Welfare, Dick Armstrong, currently the Governors Healthcare Advisory Panel (HCAP) Chair. These members all share an interest in improving the quality of healthcare in Idaho and in investment in health information technology. They come to the Commission having experiences with the healthcare system at many different levels, and represent a broad sweep of stakeholders. Members include hospital CEOs, providers, private payers, educators and community representatives. The Director of the Department of Health and Welfare (DHW), Russell S. Barron, attends all meetings. The Commission also has the support of a staff liaison from DHW.

During the first two years of its work, the Commission focused on establishing a plan to implement a health information exchange for Idaho. To that end a 501(c)(6) not-for-profit corporation, the Idaho Health Data Exchange, was established. Its status as an independent, legally established entity that is responsible to a board of directors with members from a broad base of stakeholders help to ensure that its primary commitment is to the common good.

In 2010, with the passage of House Bill 494, the duties of the Commission were slightly modified. That legislation added responsibility for monitoring the effectiveness of the Idaho Health Data Exchange (IHDE). House Bill 494 restates the Commission’s responsibility for making recommendations to the Legislature about opportunities to improve health information technology in the state, as well as recommending, “...a mechanism to promote public understanding of provider achievement of clinical quality and patient safety measures.”

House Concurrent Resolution No. 39 was also passed during the 2010 legislative session. That resolution encouraged the Commission to study stroke systems of care in Idaho and develop a plan to address stroke identification and management. Because of the investigations that followed, the Commission sent a recommendation to the Legislature in October 2011 to empower DHW to develop a plan to establish a stroke system of care.

Attention then shifted to examining other time sensitive health issues such as trauma and heart attack. This revived ongoing discussion of how Idaho could access data to better understand the true scope and cost of various health issues in Idaho. The Commission’s interest in access to health data and its importance continue to be a focus of their work and are considered with all work initiatives the Commission explores.

In December 2012, the Commission recommended that the Legislature adopt a concurrent resolution on time sensitive emergencies in Idaho. This recommendation was introduced during the 2013 legislative session. In support of that recommendation, House Concurrent Resolution No. 10 was passed. It empowered DHW to convene a workgroup to create an implementation plan and framework for a statewide system of care to address trauma, stroke, and heart attack. During the 2014 legislative session that plan was reviewed and Senate Bill No. 1329 was passed creating a time sensitive emergency system in Idaho. An update on that work is contained in this document.

Additionally, during the 2015 legislative session the Commission supported the passage of Senate Concurrent Resolution No. 104. This resolution authorized the Commission to prepare an implementation plan for a comprehensive suicide prevention program. The Commission completed that work and presented the suicide prevention plan to legislators during the 2016 legislative session.

Lastly, House Bill 375 was passed during the 2016 Legislative session reauthorizing the Health Quality Planning Commission to provide leadership for the development and nationwide implementation of an interoperable health information technology infrastructure, to improve the quality and efficiency of health care and the ability of consumers to manage their care, and to facilitate coordinated implementation of statewide patient safety standards, including identifying uniform indicators of, and standards for, clinical quality and patient safety as well as uniform requirements for reporting provider achievement of those indicators and standards. To this end the commission has focused on behavioral health in Idaho and the development of a robust web based Advance Directives platform for residents and providers in Idaho. The remainder of this document outlines the progress with these two critical efforts during this past year.

Areas of Focus for the Commission

The Commission is continually working to stay informed about health care changes that are occurring in Idaho and the nation. By keeping informed, the commission members better understand potential impacts to quality of care and how to focus efforts to pursue opportunities to improve the quality of care and health outcomes. This year, the Commission took a deep look at several initiatives including advanced care planning, behavioral health, Idaho Health Data Exchange and health insurance reform. The Commission heard from subject matter experts who provided updates on diverse health issues. The initiatives and updates considered by the Commission are summarized below.

INITIATIVES

Advanced Directives - Advanced Care Planning in Idaho

In the fall of 2017 the HQPC drafted a white paper describing its recommendations to improve the access to, consistency, prevalence and outcomes of advance care planning statewide. HQPC recommends creating a public-private collaboration to (1) establish the infrastructure and technology for a secure, accessible, bi-directional, healthcare directive registry within the Department of Health and Welfare (DHW); (2) increase the prevalence of advance care planning and document creation through widespread adoption of the non-profit Honoring Choices® Idaho framework (training, technical assistance and tools to establish a planning infrastructure in healthcare and community organizations); and (3) increase community outreach and education through a statewide public campaign.

In August 2017, the Advanced Directives Work Group was formed within the HQPC membership and other content experts within the state. The group generated a draft version of a public-private partnership that outlined a robust advanced directive plan for Idaho. The paper specifically described the development of a public and private partnership creating an effective web-based document registry technology system to increase prevalence of advanced care planning. The partnership was based on the legislature funding an effective web based document registry technology system and the staffing needed to support the technology at a cost of \$1,466,231 over a five-year period. The second interrelated portion of the program was to be supported by payers and providers and other private stakeholders. This portion of the effort focused on community engagement through marketing, training, and integration of advanced care planning practices to ensure that individuals who receive health services in Idaho utilize the system at a five-year cost of \$3,394,640. Through this partnership, it was estimated that 115,000 individuals would

utilize the technology and 400 trained facilitators would continue to assist individuals in planning conversations and use of the technology. Ultimately, the system would achieve needed improvements so that families and health care providers could know and honor Idahoan's wishes which enhances quality of care across Idaho.

In November 2017, the HQPC Task Force on Advanced Directives finalized the draft plan and budget in a white paper that was shared with the entire HQPC membership. The HQPC Task Force presented the paper for discussion with the entire HQPC. The HQPC membership decided that the task force should increase and broaden the level of community engagement/support so that a stronger proposal could be submitted for legislative backing in Idaho. To this end, the task force worked with a facilitator to bring in other community groups to enlarge the community support and financial contributions for this effort. Also, relevant information and communication tools for this effort were generated through an Executive MBA course at Boise State University.

The HQPC Task Force convened leaders from Idaho's health care, public health, education, nonprofit, and insurance sectors from across the state in the spring and summer of 2018 at Boise State University to discuss their interest in supporting and engaging in the advanced directives proposal. The result of these discussions was facilitated through a collaborative effort to move forward a proposal to the Idaho Legislature to fund and sustain Honoring Choices® Idaho and registry enhancements beginning in 2019. Using the white paper as a springboard, Elizabeth Spaulding, contracted HQPC Advance Directives Facilitator, initiated a discussion to understand what the public private partnership would look like and what commitment was available from a variety of different resources for funding and helping move the advocacy forward. The results of the effort will be decided by the HQPC membership in the summer of 2018 when recommendations will be put forward to the state legislature. Finally, the HQPC will pursue temporary funding sources through the stakeholder groups to support the current program in 2019.

A detached summary can be found in the Advanced Directives documentation ([Appendix A](#)).

Behavioral Health

In August 2017, three documents were described by Dr. Tim Dunnagan that could be used as a platform for identifying gaps in the Idaho Behavioral Health system. The first was a 2006 Institute of Medicine (IOM) report entitled Improving the Quality of Health Care for Mental and Substance-Use Conditions and the second was a 2008 Western Interstate Commission for Higher Education (WICHE) report conducted for the Idaho Legislature entitled Idaho Behavioral Health System Redesign.

In November 2017, Ross Edmunds, DHW Behavioral Health Division Administrator gave a presentation about the recommendations given through the WICHE Mental Health Program review of Idaho in 2008 and progress that had been made on the gaps evaluation and recommendations about the gaps over the past 9 years to the HQPC. This provided the HQPC members with a high-level view of the gaps in behavioral health programming in Idaho which was an item that the group agreed needed to be addressed as part of Idaho's focus on behavioral health. Subsequently, Dr. Rhonda Robinson Beal gave a presentation that broadly examined quality practices for addressing behavioral health. Multiple sources were used to generate this presentation including the IOM report that was distributed to the HQPC members. Dr. Beal's presentation helped answer a question identified by the HQPC members of what constitutes quality behavioral health care.

Based on the two presentations, feedback from the HQPC, and a follow-up WICHE evaluation of behavioral health in Idaho that was commissioned by Idaho Health and Welfare in 2018, the Blue Sky Institute at Boise State University worked with Mr. Edmunds, Dr. Robinson Beal and other content

experts to generate a strategy for behavioral health improvement in the state of Idaho. Through the facilitated activities, the metaphor of a book was used to convey the approach of describing the issues and solutions into book chapters that would generate broad basis of support and understanding to present to the Idaho legislature. This effort has led to presentations at the Idaho Health Summit to present the to the broader community. The progress made through this forum and stakeholder efforts will be presented to the HQPC in the summer/fall of 2018.

A detached summary can be found in the Advanced Directives documentation ([Appendix B](#)).

Idaho Health Data Exchange (IHDE)

In 2010, House Bill 494 added monitoring the effectiveness of the Idaho Health Data Exchange (IHDE) to the Commission's responsibilities. To that end, the Commission has received a quarterly report from Brad Erickson, the Executive Director of the IHDE, on IHDE's progress during the past year and priorities for the next year. This oversight relates to the Commission's charge to improve health outcomes in part through investment in health information technology. Mr. Erickson assumed his role in August 2017. A written annual report that is outlined below about the IHDE was submitted to the Commission for review and evaluation.

Highlights of IHDE's Progress Over the Last Year Include

Participants/Connections: The IHDE continues to enroll new participants with current participant enrollment and/or connections consisting of hospitals (17), laboratories (4), imaging centers (4), payers and provider networks (3), clinics (over 200), and access to the IHDE portal for more than 4,400 provider/staff group users. Through bi-directional connectivity, thousands of other users access IHDE data directly from within their own electronic health record systems and efficiently within their customary workflow. Other participants include assisted living centers, home health agencies and hospice facilities.

Patient Centered Medical Home (PCMH) and State Healthcare Innovation Plan (SHIP): The IHDE continues to support state healthcare transformation initiatives, notably the State Health Innovation Plan (SHIP), with an emphasis on establishing bi-directional data exchange between the IHDE and primary care providers. Forty-one new clinics and one hospital were connected bi-directionally since July of 2017. By January 2019, approximately 142 SHIP clinics will have bi-directional connectivity with the IHDE. This method of exchanging data is key to helping drive patient-centered care to transform to a Patient Centered Medical Home (PCMH) model across the state. The IHDE will also continue to support the PCMH model through connecting other Medicaid Healthy Connections Clinics, with the added benefit of those clinics moving to higher Medicaid tier reimbursement levels. In fact, one of the criteria of Medicaid tier reimbursement level advancement is connectivity with the IHDE.

Regional Connectivity: In further support of PCMH initiatives, the IHDE is an active participant in the Patient Centered Data Home (PCDH) initiative both regionally and nationally. Through this collaborative effort with other Health Information Exchanges (HIE's) in other states, the IHDE is currently exchanging admission, discharge, and transfer (ADT) data and alerts with eight neighboring western states.

Customer Engagement and Satisfaction: The IHDE has made a concerted effort to increase customer engagement to better provide value to our customers and participant organizations. From October 2017 – June 2018, the IHDE has completed approximately 150 customer visits and has gathered important use case information. Additionally, during that timeframe, nearly 800 users received IHDE training. The IHDE also engaged a third-party organization to deliver a customer satisfaction survey. Over 300 users responded and 85% reported satisfaction with the IHDE.

Financial/Operations: Through strong partnerships with key stakeholders and customers, the financial position of the IHDE has improved significantly. Cumulative Net Equity (Cumulative Net Income since organization inception) has improved from a deficit of (\$275,000) to a positive equity position of \$500,000 over the past 10 months. Cash Balance has improved from \$95,000 to approximately \$1,000,000 and the balance in long-term debt has improved from \$300,000 to a zero balance.

The IHDE – Priorities Moving Forward

The IHDE has benefited from the strong partnership with the DHW in helping evolve to a higher performing, sustainable organization. The IHDE will continue to partner with the DHW in contracts to take full advantage of available grant-based funding through the Health Information Technology for Economic and Clinical Health Act, State Innovation Model grants and other funding opportunities. Many of the key initiatives below, particularly the SHIP, technology platform upgrade, and the health information exchange assessment and strategic planning process are funded by those programs.

Connections: The IDHE staff will complete all possible bi-directional connections with SHIP participating clinics, other Medicaid Healthy Connections Clinics, and very importantly, additional rural hospital organizations. Connection for at least fifty more clinics and ten more hospitals over the next twelve months. Drive connections with other non-traditional provider organizations such as dentists, optometrists, chiropractors, etc. There is significant opportunity and value for these organizations who continue to exchange records through inefficient, costly, and potentially risky fax and paper delivery methods.

Regional/National Connectivity (PCDH): The IDHE staff will increase connectivity of Admissions, Discharge and Transfer (ADT) data to western states in the collaborative while exploring connections with other states where feasible. Also, the staff will advance to exchanging Continuity of Care Documents (CCD) and other detailed patient data, in addition to the rather than just ADT data with other states.

Technology Platform: The IDHE staff will upgrade from a single vendor platform to a more robust, tiered technology platform to reduce risk, provide efficiencies and cost savings, as well as more robust methods to exchange data and provide data analytics capabilities. This will also enable providing a platform for an all claims and clinical database, which could integrate clinical data and claims data in a central, trusted, independent data warehouse. Additionally, the platform will provide a way for patients to become more engaged in their own health, by providing a patient portal where they can access their complete medical records from all providers where they have received care.

Customer Engagement: The IDHE staff will continue to engage with customers to better understand their needs and desires and develop and delivery training to improve user adoption. Particularly, collaborate with payers and provider networks to better meet their data needs.

Operations and Sustainability: The IDHE staff will complete an independent assessment by a third party HIE Consulting to develop a three to five-year Strategic Plan with a sustainability model to lessen dependence on state and grant funding over time. Part of this effort will also be to review and recommend the appropriate stakeholder engagement and governance model for the IHDE. Through these efforts we will continue to build a high performing team with less dependence on contracted resources. Additionally, the organization will transition from a 501(c)6 entity type to a more appropriate 501(c)3 entity to allow for more favorable vendor treatment and fund-raising opportunities.

A detached summary can be found in the IHDE presentation in [\(Appendix C\)](#).

Health Insurance Reform

The HQPC members considered a variety of insurance options for the state of Idaho to expand and improve access to medical care and prevention services to residents across the state. Jeff Crouch, DHW Western Hub Regional Director gave a presentation on moving from volume to value based payment method for Medicaid services. Specifically, the goals of the payment reform model were to develop a provider-based program that would lower total cost, improve access and quality, incorporate shared savings and shared risk, pay for value not volume, and engage the community through local advisory groups. The mechanism for payment reform would be accomplished through the development of regional care organizations, patient centered medical homes, and bundled payments with incentives built in for providers.

The HQPC members also considered the HCAP Dual Waiver Strategy (1332 & 1115 waivers) that was presented by Lori Wolff, DHW Deputy Director. There were two parts to the strategy with the first portion being a 1332 waiver. The intent of this effort was to waive the Advance Payment of Premium Tax Credit (APTC) ban (Idaho Medicaid and subsidized insurance) on citizens up to 100% of FPL which would allow those adults not currently covered to receive a tax credit and purchase private insurance on the exchange at an affordable cost to individuals with taxable income. The 1115 Medicaid waiver was proposed to cover individuals under 65 years old who are not otherwise eligible for other full Medicaid programs and do not have access to employer support coverage. Furthermore, the waiver would have allowed individuals up to 400% of FPL and individuals with complex medical conditions (examples: Metastatic Cancers Stage 4, Hemophilia, End State Diseases and Bone Marrow Disorders) to participate in the funding strategy.

The legislature did not act upon the insurance recommendations. Given that 60,000 signatures were obtained to have the federally supported expansion of Medicaid be put on a statewide ballot, this item will be tabled until this voter initiative is resolved.

UPDATES

Graduate Medical Education (GME)

In August 2017, Dr. Ted Epperly gave a brief update on Graduate Medical Education (GME) in Idaho and a more in-depth presentation at the November 2017 HQPC meeting. During the November meeting, Dr. Epperly presented the GME 10-year plan which was addressed at the State of the State address by the Governor. This statewide plan would help keep physicians in Idaho. At full maturity the program cost would \$16.5 million per year and expand to approximately 1500 physicians compared to the 500 currently in the Idaho program. The approach would be governed by a GME Council that would be staffed equally across four areas including Medicaid/Medicare/Veterans, Hospitals, Universities and the State of Idaho. This initiative will have a significant and positive impact on the recruitment and retention of practitioners (especially physicians) associated with GME.

Time Sensitive Emergencies (TSE)

In February 2018, Wayne Denny, DHW Bureau of Emergency Medical Services & Preparedness Chief, described the effort that was started in 2015 when Idaho was one of the few states that didn't have an organized Time Sensitive Emergencies (TSE) system in place. Three of the five leading causes of death in Idaho are trauma, stroke and heart attacks. In 2013, the HQPC TSE initiative was moved to HCR10 as a TSE workgroup. The TSE workgroup has made significant progress on getting facilities designated throughout the state of Idaho. The program is now funded through a fee structure that varies depending on level and type of facility providing services and is maintained through a registry. The TSE registry expanded during 2018 and is moving to a paperless system. Going forward plans include analyzing current data to improve patient care and real-time data reporting. The TSE has helped to improve quality, tighten processes, inform key decision makers, share best practices amongst staff and peers, and create greater education opportunities.

A detached summary can be found in the Time Sensitive Emergencies overview ([Appendix D](#)).

Membership Updates

Former Member:	Replaced By:	Agency/Role:
Scott Kreiling	Kenneth Bramwell	Regence Blue Shield Executive Medical Director
Julie Lineberger	Brad Erickson	Idaho Health Data Exchange (IHDE) Executive Director
David Pate	Barton Hill	St. Luke's Regional Medical Center VP & Chief Quality Officer
Rhonda Robinson Beale	Daniel Meltzer	Blue Cross of Idaho SR VP & Chief Medical Officer
Casey Meza	Patricia Richesin	Kootenai Health Representative

Future Considerations

Idaho is currently embarking on several initiatives that will shift how healthcare is provided. The SHIP is transforming Idaho's healthcare delivery system from a fee-for-service, volume-based system to a value-based system of care focused on improving health outcomes and reducing costs. Idaho has seen the implementation of a statewide suicide prevention program and are pursuing technology for improvements to the Advanced Directive system. New health issues continue to emerge, such as abuse of prescription medications and behavioral health needs, which are significant across Idaho. Commission members are committed to maintaining a focus on this changing environment as they move forward with their work. They will continue to examine ways to best use the expertise and authority they hold to promote health and patient safety, planning, and improved quality of care and health outcomes for all Idahoans.

Appendices

APPENDIX A - Advanced Directives (AD)

Advanced Care Planning Registry and Prevalence Program Health Quality Planning Commission (HQPC) White Paper

Problem Statement

Seventy-five percent of people in life-threatening situations or nearing end of life cannot make or communicate decisions about the medical care they want.¹ Family members and health care providers face daunting decisions when a person's preferences are unknown. The default is to treat, leaving families and providers guessing if treatment is what that person wants. Ninety percent of Idaho adults say that talking about these future decisions (advanced care planning conversations) with family and health care providers is important, but less than one-third have done so² only a small fraction of Idaho's adult population has submitted an advanced directive document to the Idaho Healthcare Directive Registry.³ Addressing these profound disconnects requires:

- (a) increasing the prevalence of advanced care planning conversations that include *discussions of goals and preferences for medical care in the event a person is unable to make his/her own health care decisions*.
- (b) documenting individual's informed preferences through advanced directives and Physician Orders for Scope of Treatment documents.
- (c) improving outdated, poorly utilized document registry technology.
- (d) communicating individual's preferences across settings of care.

Factors Critical for Success

Alignment with the Charge of Health Quality Planning Commission- These requirements align with the charge outlined in Idaho Statute 56-1054 that created the Health Quality Planning Commission (HQPC). Specifically, the statute directs the (HQPC) to improve health outcomes through investment in health information technology through networked electronic health information that allows quick, reliable and secure access to promote patient safety and best practices. Furthermore, the HQPC is to make recommendation to the legislature and the Department of Health and Welfare on opportunities to improve the capabilities of health information in the state. This white paper was crafted to help address this directive while addressing the four requirements outlined in the problem statement related to advanced directives.

Public Private Partnership- The generation of an effective advanced care planning system (technical requirements for document registry technology and community training/engagement to ensure utilization of the technology) for individuals who receive health care within Idaho based delivery systems requires meaningful partnerships between the Idaho Department of Health and Welfare and private stakeholders such as payers and providers. Therefore, participation in the development, funding, scaling and ongoing support of this system will need to take place across these entities in order for this partnership to be successful.

Recommendation

Based on the clear need and rationale, the HQPC recommends that the Idaho Legislature and private stakeholders e.g., payers/providers invest in the Advance Care Planning Registry and Prevalence Program to achieve needed improvements so that families and health care providers can know and honor Idahoan's wishes. State-wide, systematic, standardized advance care planning and registry improvements will result in continuity of care,

¹ Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life. Institute of Medicine of the National Academies, 2014

² Idaho End-of-Life Survey, Boise State University, 2006

³ Personal communication with Idaho Secretary of State's Office.

respect for individual's freely-made informed decisions, matching of medical care to individual's informed preferences, and preventing harm and suffering by providing only medical care individuals say they want.

The Health Quality Planning Commission recommends a phased investment (see Appendix A for a detail of the request) between 2019-2023 in the Department of Health and Welfare (\$1,166,231) and payers/providers/others (\$3,394,644) totaling \$4,860,875 to achieve two equally critical objectives outlined in a five-year timeline and measurable outcomes table (Appendix B).

Description

Objective 1. Private Contribution: Integrate evidence-based advanced care planning practices statewide.

Private investments will integrate evidence-based, standardized, person-centered advanced care planning practices in communities statewide. By 2023, the investment will prepare 400 skilled facilitators in 200 health care and community-based organizations across the state to increase the prevalence of advanced care planning conversations between individuals, family members, and health care providers and promote completion of appropriate documents (Appendix B). By 2023, the investment will result in 115,000 Idahoans participating in advanced care planning conversations, and the groundwork will be laid for facilitators to guide an average of 25,000 conversations annually thereafter.

This outcome will be achieved by scaling the Honoring Choices® Idaho (HCI) initiative, an established advanced care planning collaborative convened by Jannus, a well-respected community-based nonprofit. HCI launched in 2015 with start-up funding committed through a partnership with Saint Alphonsus and St. Luke's health systems and to date has resulted in HCI coordinating implementation of evidence-based advanced care planning practices across the two health systems and several community organizations. Implementation includes:

- (1) systems redesign to integrate planning conversations into routine patient care.
- (2) standardized, competency-based skill building of staff who facilitate planning conversations.
- (3) consistent, common constituent and provider engagement materials and strategies.
- (4) a standardized advanced directive document.
- (5) collection and sharing of data to continuously improve.
- (6) sustainability planning (*embedding sustainable expertise in each organization and building capacity of "instructors" to train additional facilitators*).

The Department of H & W would act as the *fiduciary and performance monitor of HCI*. *HCI, in consultation with the Department, will strategically recruit, train, and mentor diverse organizations across the state in implementing standardized, evidence-based advanced care planning practices. Targeted organizations include primary care clinics (those participating in Idaho's State Healthcare Innovation Program and community health centers), home health agencies, care coordination programs, and skilled nursing facilities, as well as community-based health/social services organizations such as parish nurse consortiums, Area Agencies on Aging, community health worker programs, faith communities, assisted living communities, and disease-focused agencies. Organizations with broad geographical reach across Idaho will be prioritized, as well as organizations that will use their new "instructors" to train additional ACP facilitators (furthering the scaling of the program). All trained facilitators, instructors, and team members will participate in annual shared learning activities coordinated by HCI to ensure consistency in approaches, to share effective strategies, and to look for opportunities for further expansion. The deliverable achieved by 2023 is a functioning, consistent model of advanced care planning across the state that provides opportunities for Idahoans' and their families to participate in planning conversations.*

Objective 2 Public Contribution: Staffing and infrastructure to support web based document registry technology.

The public contribution would provide a secure, accessible mechanism to ensure documented plans (advanced directives and Physician Orders for Scope of Treatment) to be made available wherever and whenever individuals need them. By 2021, the investment will result in a real-time, interoperable web-based platform that will be fully functioning and appropriately accessible to consumers, Idaho health care providers across settings of care, and

Idaho emergency responders. The specific characteristics and capabilities of the electronic system will be detailed in this narrative after the scheduled meeting with VYNCA, the platform vendor on August 8th, 2017. The HQPC workgroup will be in attendance for this session.

Risks / Mitigation

One risk is that participating organizations (who are integrating advanced care planning practices) do not perform as expected. An MOU will be created to ensure each organizations and parent organization (if appropriate) fully agrees to the expectations of participation and the support/training provided by HCI and the Department of H&W. Expectations will include identifying and supporting appropriate staff to train and serve as facilitators and instructors; target goals for conversations; outreach and data collection; utilization of the registry technology; shared learning; and sustainability planning.

Financial Projections

The cost projections shown in Appendix A reflect the private public partnership between the state and private stakeholders that is the cornerstone of this proposal. The costs for the electronic document registry technology and the staffing to support this system would be resourced by Health and Welfare through funding by the state legislature. The oversight and performance monitoring of the community engagement and advanced care planning practice integration would be conducted by Health and Welfare. The costs of engaging communities, training, and capacity building would be covered by the private stakeholders. Again, the two features of the program need to be orchestrated in order to maximize the success of the intervention.

Summary

The proposed development of a public and private partnership of an effective web-based document registry technology and system to increase prevalence of advanced care planning will improve the quality of health care for individuals and their families in profound ways. The partnership is based on the legislature funding an effective web based document registry technology system and the staffing needed to support the technology at a cost of \$1,466,231 over a five-year period. The second interrelated portion of the program is supported by payers and providers and other private stakeholders includes marketing, training, and integration of advanced care planning practices to ensure that individuals who receive health services in Idaho utilize the system at a five-year cost of \$3,394,640. Through this partnership, 115,00 individuals will be utilizing the technology and 400 trained facilitators will continue to assist individuals in planning conversations and use of the technology. Ultimately this system will achieve needed improvements so that families and health care providers can know and honor Idahoan's wishes which enhances quality of care across Idaho.

APPENDIX A (continued)

ESTIMATED BUDGET					
Idaho Advanced Care Planning Registry and Education/Training Program - Basic Model					
		Year 1 (SFY 20)	Year 2 (SFY 21)	Year 3 (SFY 22)	Justification
Objective #1: Establish the infrastructure and technology to support a web based document registry.	(See note below)				
Technology		\$ 244,000	\$ 56,650	\$ 58,350	Y1 ESTIMATES ONLY: Cost includes annual license (\$55,000 plus 3% increase per year based on industry standard), conversion of existing registry documents records to new system (34,000 records), one-time perpetual license (\$155,000). Y2/3: Cost includes annual license. Note: there are options for 'subscription fees' for larger hospitals/health systems to integrate product to EHR based on annual Medicare discharges and for small hospitals to have documents 'pushed' to their EHR. Subscriptions not necessary as hospitals can use web-based product and not included in this cost.
Personnel		\$ 167,874	\$ 170,550	\$ 175,367	This includes staff to support the registry contracts, use, hospital coordination, etc. Costs include salary and benefits for 2.0 FTE (\$155,874). It also includes \$2,000 in capitol outlay for office furniture for staff (one time SFY 20), and \$10,000 ongoing for operating expenses and technology training. Salaries calculated at 3% increase each year.
Health Program Manager (M)	\$ 81,593				
Interoperability / Data Quality Coordinator (M)	\$ 74,281				
Subtotal		\$ 411,874	\$ 227,200	\$ 233,717	\$ 872,791
Note: This cost is based on a estimate of \$1 per record transferred from existing registry to new one (as of April 2018 there are 34,000 records to migrate). This cost could be higher. Personnel costs are based on costs of managing similar data systems but may be less depending on the requirements of the vendor.					
Objective (2): Integrate evidence-based advanced care planning practices statewide.					
Honoring Choices Idaho program to integrate advance care planning skills and practices within 200 health care and community organizations		\$ 348,138	\$ 378,588	\$ 382,935	HCI is currently funded by SAHS and SLHS and provides tools, training and technical assistance to health and community organizations in the health systems' catchment areas. A statewide, detailed dissemination budget has been provided for this three-year scaling effort. The aim is to establish the HCI program in two regions per year over the 3-year period (HCI is already established in Region 4). Subsequent years will focus on maintenance of tools/training repository.
Statewide outreach/marketing		\$ 100,000	\$ 200,000	\$ 200,000	These costs are for a marketing campaign targeting consumers and providers to participate in advance care planning conversations and complete ACP documents. The campaign will direct providers and consumers to use the registry, ensuring the investment in the technology results in high utilization.
Subtotal		\$ 448,138	\$ 578,588	\$ 582,935	\$ 1,609,661
Yearly Total		\$ 860,012	\$ 805,788	\$ 816,652	\$ 2,482,452
13-Jul-18					

APPENDIX A (continued)

Five-Year Timeline and Measurable Outcomes:

The table below highlights the timeline for key implementation steps and objectives, evidence of progress to date, and anticipated measurable outcomes.

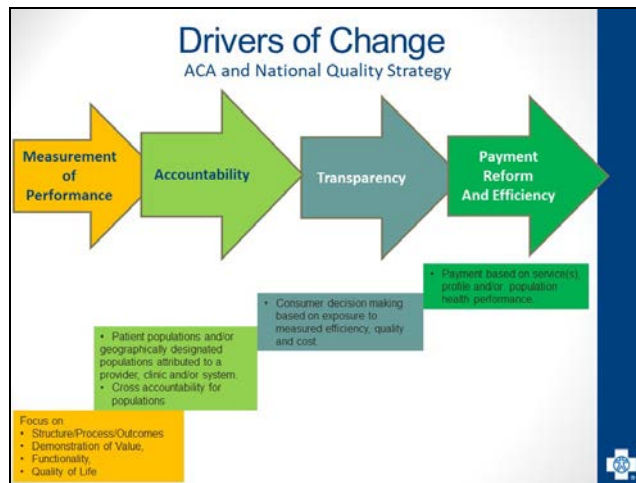
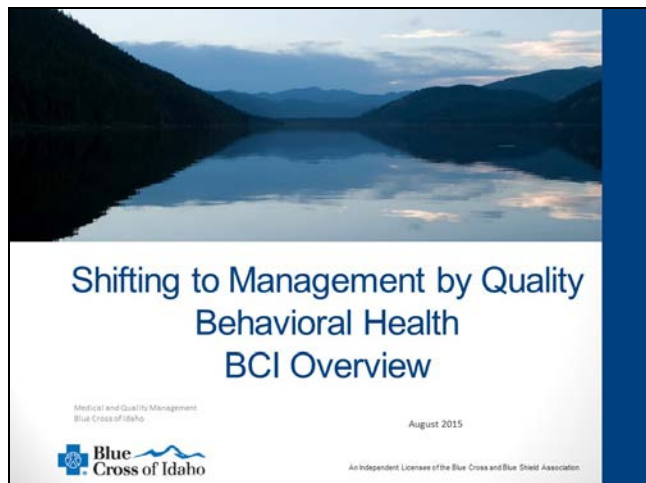
Key Implementation Steps	Start Up 2016-2018	Scaling 2019 – 2021	Sustaining 2022-2023	Measureable Outcomes:
Recruit healthcare and community sites. Site leaders and teams participate in integration training.	40 sites	50 sites/year	5 sites/year	200 healthcare / community sites sign MOU and participate in initiative.
Facilitators trained / competency is monitored.	75	100 / year	10-15/year	400 facilitators trained in competency-based skills. 100% self-report competency.
Conversations occur as routine part of care or service delivery.	5,250 conversations	55,000 conversations	25,000 conversations /year	Prevalence of planning: 115,000 Idahoans participate in facilitated ACP conversations.
Community outreach occurs.	12 events	100 events/year	30 events/year	372 community presentations/outreach events occur.
Key site staff trained as “instructors.”	8	12	2	22 instructors trained and lead facilitator training.
Participant satisfaction surveyed.	x	x	x	90% of participants rate the ACP conversation >3 (out of 5)
Organizations participate in shared learning.	x	x	x	100% of organizations participate in annual shared learning activities.
Baseline data collected.	x			*% of patients / clients who have an advanced directive in medical record or in state registry
Long term outcome measures developed and collected			X	90% of sample of decedent records find care provided at EOL is consistent with documented patient wishes
Technology bid process occurs	x			
Technology purchased, set up, and tested and training begins	x			

APPENDIX B - Behavioral Health presentation to HQPC

Informational Links:

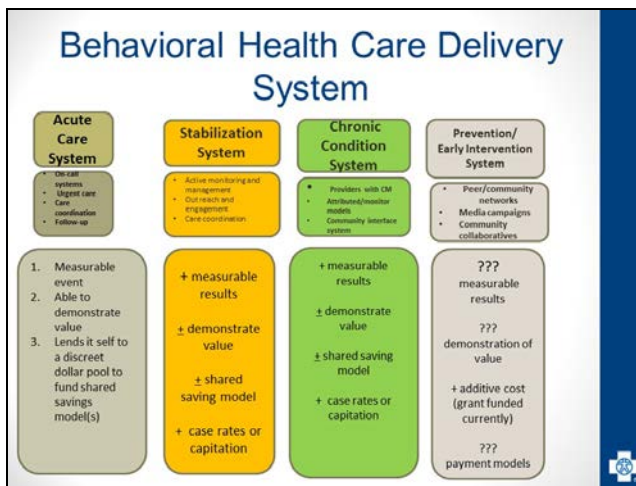
- Division of Behavioral Health's website:
<https://healthandwelfare.idaho.gov/Medical/MentalHealth/tabid/103/Default.aspx>
- 2018 WICHE Report:
[2018 WICHE Report: System Redesign Status Update and Mental Health Service Array Assessment](#)

Management by Quality Behavioral Health Overview presentation:



How Move the BH Provider Community to a Well Functioning Delivery System?

- Collaboration between public system and private system
 - Principles
 - Tenets
 - Strategy
 - Points of collaboration
- Organize a executive board to oversee
- Organize a working administrative layer
- Implementation Plan



Components of the Change

There are fundamental changes to health care practice that are necessary to shift to a pay for performance structure:

- **Attribution** –Assigning a patient population to a provider or providers to be in their denominator of measurement.
- **Accountability/ single and shared** – Measurement methodologies of the outcomes of acute and/or chronic episode(s) of treatment forces accountability on the part of the provider(s) to the measured outcome of care
- **Medical necessity, quality and cost** – become added dimensions to clinical decision making.



The Denominator

Population Attribution

- In the new payment models, patients providers touch are in their denominator and those who achieve the desired metric will determine the numerator.
- Measurements are focused on a specific service, (e.g. surgery) and/or a treatment episode, (e.g. use of antidepressants to treat depression) with distinct starts and identifiable outcomes.
- Episodes of care are defined as services naturally delivered during a typical course of treatment from start to at least stabilization or recovery.



The Denominator

Shared Accountability

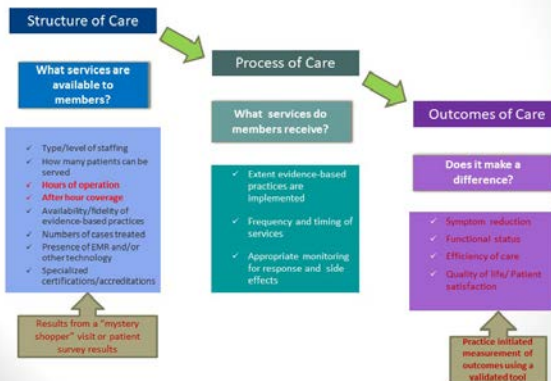
- Most metrics are patient centric
- The measurement applies to all participants caring for the patient
 - Example #1 -Primary Care Provider is jointly responsible for assuring quality for both General Health and Substance Use Disorder and Mental Health care
 - Example # 1 -Behavioral Health providers (Mental Health & Substance Use Disorder) are equally responsible for assuring quality for Substance Use Disorder and Mental Health and some General Health factors, (e.g. annual physical exam, screening for diabetes and cholesterol for those on antipsychotics)



Selecting Metrics



Quality through the Examination of Structure, Process, and Outcomes of Care – Future Measures



Provider Score Card - B



Creating a BH Collaborative

- Establish a local BH provider panel to provide ongoing input and recommendations to the next step, process, future measures and relevant policies.
- Panel should have a fair representation of BH providers from the Idaho provider community.
- Meetings will be limited to no more than 2 per year.
- Goal will be to continuous improve behavioral health care for the Idaho community.
 - Data reporting on performance
 - Data analysis and discussion – System improvement rounds
 - Problem solving
 - Provider level
 - System level




APPENDIX C - Idaho Health Data Exchange (IHDE) presentation to HQPC

IHDE Update

Health Quality Planning Commission Meeting

February 7, 2018
Brad Erickson, Executive Director



1

Highlights, Focus and Activities

Highlights:

- ✓ Built ~ 180 Clinic Connections; 32 Key Deliverables Completed
- ✓ Strong Financial Position ~ \$800K in cash; >\$600K Net Income
- ✓ Strong team in place; continuing to build

SHIP & Healthy Connections Support

Customer Engagement

Operations and Technology Infrastructure

Build a High Performing Team

Strategic and Sustainability Planning



2

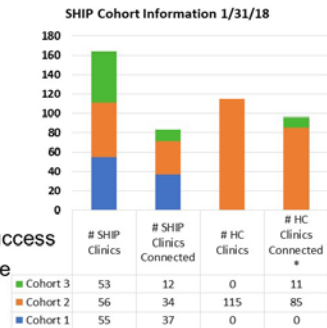
SHIP and Healthy Connections Support

Bi-Directional Connections:

- Cohort 1: 37 of 55 thus far
- Cohort 2: 34 of 56
- Cohort 3: 12 of 53
- Healthy Connections: 96
- ❖ 20 Organizations on Hold


Other SHIP Support:

- EMR Vendor Negotiation Success
- All 32 Key Deliverables Done
- Data Quality Improvement
 - Data reporting accuracy
 - Data analyst support



	# SHIP Clinics	# SHIP Clinics Connected	# HC Clinics	# HC Clinics Connected *
Cohort 3	53	12	0	11
Cohort 2	56	34	115	85
Cohort 1	55	37	0	0

*Count specific to Cohort



Customer Engagement - Survey Results

- Online survey (11/13-11/27/17), Interviews with 12 of respondents
- Population: 4,600+ users contacted; 310 qualified responses (7%)

Overall Satisfaction


- 69% = "Mostly" (51%) + "Completely" (18%)
- 85% Satisfied or Higher

Performance

- 90% IHDE provides answers in a timely manner
- 51% impacted by IHDE downtime, but still high scores


Access

- 90% access IHDE directly via portal
- 39% access IHDE >2 times per day
- 23% access IHDE >2 times/week



Customer Survey Results – Summary Findings

- High Satisfaction with and Need for the IHDE
- Data Availability and Printing Functionality - Top Concerns
- Training/Awareness and User Specific Materials Needed
- Requests for Add'l Functionality/Improvements Minimal
- IHDE Value is High, Drives Better Care, Efficiencies
- Data Access, Patient Results, Data Search Most Important
- IHDE is Recommended by Most Users



5

Customer Engagement & Sales & Marketing

Customer Engagement


- ✓ 30 of 30 Clinics visits completed
- ✓ 10 of 10 Hospital visits completed
- ✓ 14 prospective customer visits
- ✓ Two "quick" handouts created for clinic visits

Key SHIP Deliverables Completed

- ✓ Hospital Engagement Plan
- ✓ Participant Licensing Plan
- ✓ Tech Platform Communications Plan
- ✓ IDHW VN Access/Licensing Plan (submitted)

Driving Better Capabilities

- ✓ Training Coordinator hired
- ✓ Neighboring HIE's and National and Western Region HIE engagement



Operations and Infrastructure

Current Platform

- System down 9/20 4:30PM – 9/26 2:00AM) ~5.5 days, 123 hrs
- System now stabilized, performance level on target
- Over \$350K of financial remedies negotiated with vendor (Orion) vs. contracted remedies due of ~\$20K

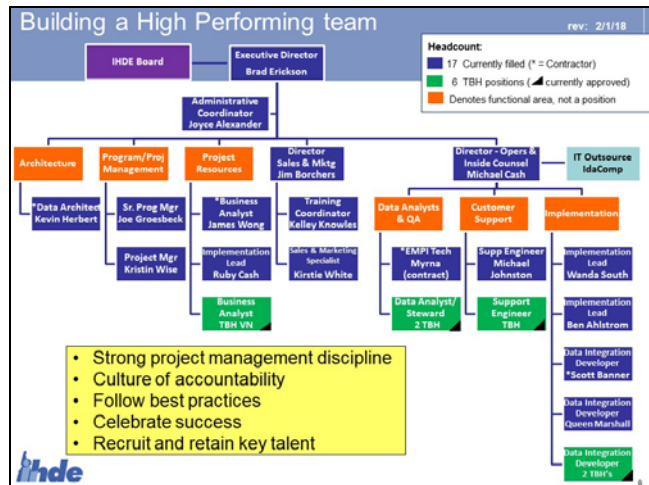
Platform Upgrade

- Planning and configuration in progress
- Improved stability, data access, analytics tools
- Lower cost, more control over build process
- Target go-live June 2019

Other Operations Items

- Security & Privacy Risk Assessment ~ March 2018
- Customer Service ticketing system (Zoho) live 1/15

7



Strategic/Business Planning Components

Financial Plan

- Long-term sustainability model
- Transition from 60% Grant Revenue FY18 to 20% FY21
- Conservative expense budget

Sales and Marketing

- Focus Strategy, Mission, Vision, Branding, Licensing Policy
- Detailed Sales forecast
- Customer engagement and value; use cases

Technology Plan and Roadmap

High Level Timeline:

- March 2018 - Draft present to Board
- May 2018 - Finalize and Approval by Board

ihde

10

Next Steps and Addressing Challenges

- ☐ Complete SHIP Cohort builds; Healthy Connections builds
- ☐ Capitalize on new sales opportunities
- ☐ Complete Strategic and Long-term Sustainability Plan
- ☐ Finalize 2018 Success Metrics with Board
- ☐ Continue to drive platform upgrade
- ☐ Continue customer engagement activities/visits – drive understanding of value proposition and use cases
- ☐ Continue to build relationships with partners
- ☐ Continue to build high performing team (recruit key positions)
- ☐ Continue to drive lower cost model - lessen reliance on contractors over time




APPENDIX D - Time Sensitive Emergencies (TSE) presentation to HQPC

Health Quality Planning Commission


"Get the right patient, to the right place, at the right time"

Time Sensitive Emergency Update

Wayne Denny
Bureau Chief
Bureau of EMS & Preparedness

 IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

2/7/2018

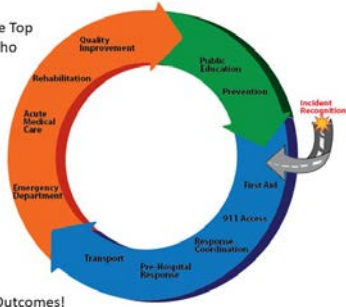
 IDAHO TIME SENSITIVE
EMERGENCY SYSTEM
Trauma | Stroke | STEMI


Why TSE?


Trauma, Stroke, and STEMI: Three of the Top Five Preventable Causes of Death in Idaho

No Organized System in Idaho

Systems Drive Improvement = Better Outcomes!



 IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

 IDAHO TIME SENSITIVE
EMERGENCY SYSTEM
Trauma | Stroke | STEMI

HISTORY

2012

HQPC

2013

HCR10 - TSE Workgroup

2014

Legislation Signed
TSE Council Formed

2015

TSE Regional Committees Formed
TSE Rules

2016



First Facility Designated


2017


TSE Registry - Stroke and STEMI

2018

Paperless Application Process

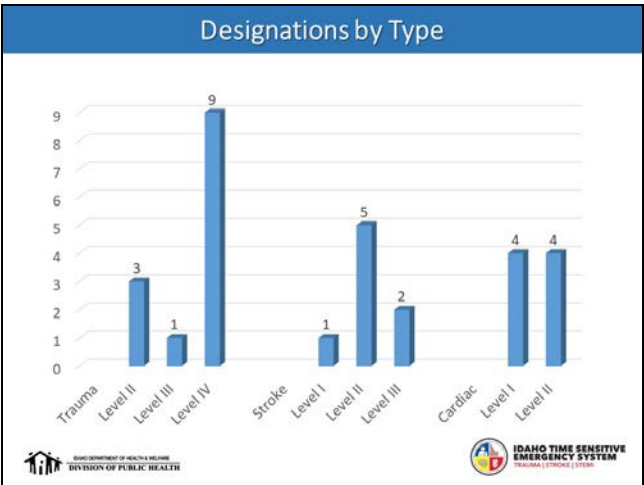


 IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

 IDAHO TIME SENSITIVE
EMERGENCY SYSTEM
Trauma | Stroke | STEMI

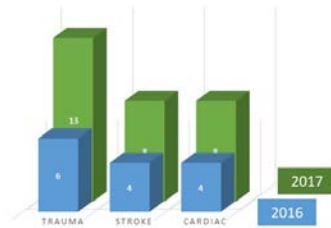
TSE Facilities





Name of Facility	Trauma	Stroke	STEMI
Saint Alphonsus Regional Medical Center	Level II	Level I, Level II	Level I
Eastern Idaho Regional Medical Center	Level II	Level II	Level I
St. Luke's Boise		Level II	Level I
St. Luke's Meridian		Level II	Level I
Lost Rivers Medical Center	Level IV		
Clearwater Valley Hospital	Level IV		
Teton Valley Hospital	Level IV	Level III	Level II
Kootenai Health	Level II		
St. Luke's Magic Valley		Level II	Level I
Boundary Community Hospital	Level IV		
Bonner General Hospital	Level IV	Level III	Level II
St. Luke's Nampa			Level II
St. Luke's Fruitland			Level II
St. Joseph Regional Medical Center	Level III		
Steele Memorial Medical Center	Level IV		
Neill J. Redfield Memorial Hospital	Level IV		
Madison Memorial Hospital	Level IV	Level III	Level II
Syringa Hospital	Level IV		
St. Mary's Hospital	Level IV		
West Valley Medical Center			Level II
Caribou Memorial Hospital	Level IV		
Bear Lake Memorial Hospital	Level IV		

Designation History



Designation Process

- Criteria - consider nationally accepted standards
- Program Staff - administrative support and assistance
- Site Surveyors - from within the system when possible
- Application and site survey results - TSE Council
- Designation - three years



Designation Criteria

Anesthesiology - Trauma

	Idaho	ACS
Level I	MD	MD
Level II	MD or CRNA	MD
Level III	MD or CRNA	MD or CRNA
Level IV	NA	No Designation
Level V	NA	No Designation

Designation Fees

	Three Years/Annual
Trauma Designations	
Level I	\$45,000/\$15,000
Level II	\$36,000/\$12,000
Level III	\$24,000/\$8,000
Level IV	\$12,000/\$4,000
Level V	\$3,000/\$1,000
Pediatric LI & LII	\$36,000/\$12,000
Stroke Designations	
Level I	\$21,000/\$7,000
Level II	\$12,000/\$4,000
Level III	\$1,500/\$500
STEMI Designations	
Level I	\$21,000/\$7,000
Level II	\$1,500/\$500

Designation Fees

Three Years/Annual		
Trauma Designations		
Level I	\$45,000/\$15,000	ACS - \$21,000 Consultative Visit
Level II	\$36,000/\$12,000	
Level III	\$24,000/\$8,000	
Level IV	\$12,000/\$4,000	
Level V	\$3,000/\$1,000	
Pediatric LI & LII	\$36,000/\$12,000	
Stroke Designations		
Level I	\$21,000/\$7,000	Commission - \$24,000 Two Year Level II Stroke
Level II	\$12,000/\$4,000	
Level III	\$1,500/\$500	
STEMI Designations		
Level I	\$21,000/\$7,000	
Level II	\$1,500/\$500	

Data

- Idaho Trauma Registry - 2002
- TSE Registry - expansion currently underway
- Baseline data - PERCS (EMS) and TSE registry
 - ED dwell times, transport times, etc.
 - May 2017 - "Farming and Ranching Related Injuries in Southern Idaho"
 - Published in the American Journal of Surgery
 - 2014 trauma registry and facility data from five participating hospitals
 - Assess impact that the TSE system may have on trauma outcomes over three to five years

Data Challenges

- Not all facilities self-report trauma data
- Large cost of the registry
- No requirement for real time reporting



Why Seek Designation?

- No funding for stroke and cardiac
- Quality spreads throughout
 - Lower ED dwell times
 - Patients treated more systematically and efficiently
 - Transferred or discharged as needed
 - Increased patient satisfaction
 - Serious diagnoses are identified earlier
 - Earlier transport determinations



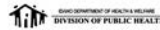
Why Seek Designation?

- Consultation with TSE staff and peers
- Education
 - Rural Trauma Team Development
 - Stop the Bleed
 - ISN focusing on TSE based simulations



What's Next?

- Increased EMS involvement
 - EMS Agency designation
 - Closer connection to hospital
- Data!
- Change & improvement!
- Sepsis?



Questions?

Wayne Denny
Bureau Chief
Bureau of EMS & Preparedness
Division of Public Health
wayne.denny@dhw.idaho.gov
(208) 334-4000
www.idahoems.org

Christian Surjan
TSE Program Manager
Bureau of EMS & Preparedness
christian.surjan@dhw.idaho.gov
(208) 334-4000
www.tse.idaho.gov

